Addressing Readiness to Change PTSD with a Brief Intervention: A Description of the PTSD Motivation Enhancement Group

Ronald T. Murphy
Craig S. Rosen

SUMMARY. Poor response to PTSD treatment and the disorder's chronicity among combat veterans may at least partly be due to ambivalence about the need to change PTSD symptoms and related problems. The PTSD Motivation Enhancement (ME) Group described in this article was developed to address problem acknowledgement among veterans in treatment for PTSD. This manualized, brief therapy intervention is conceptually based on the Stages of Change and draws on Motivational Interviewing techniques. The goal of the PTSD ME Group is to help patients make decisions about the need to change any behaviors and coping styles not previously recognized as problematic so that patients will perceive PTSD intervention components as more relevant, thereby fostering greater engagement in treatment and more adaptive post-treatment coping. The authors discuss theory and research findings related to

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Address correspondence to: Ronald T. Murphy, Department of Psychology, Dillard University, Dent Hall, 2601 Gentilly Boulevard, New Orleans, LA 70122.

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the group, the structure and content of the intervention, and important clinical issues to consider when implementing the group.

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Combat-related posttraumatic stress disorder (PTSD) has been labeled a chronic disorder, especially among Vietnam veterans (Bremner, Southwick, Darnell, & Charney, 1996; Zlotnick, Warshaw, Shea, Allsworth, Pearlstein, & Keller, 1999). Although PTSD treatment can be effective (Foa, Keane, & Friedman, 2000; Sherman, 1998), several studies of combat veterans have found little change in PTSD symptoms following intensive treatment (Fontana & Rosenheck, 1997; Johnson, Rosenheck, Fontana, Lubin, Charney, & Southwick, 1996). Consequently, many programs treating chronic and complicated cases of PTSD have shifted from a symptom reduction model towards a "rehabilitation model," which tries to maximize patients' coping skills (Mellman, Kutcher, Santiago, & David, 1999).

Poor response to PTSD treatment and the chronicity of the disorder may at least partly be due to ambivalence about changing PTSD symptoms and related problems (Murphy, Cameron, Sharp, & Ramirez, 1999). In our experience implementing coping-focused treatments such as conflict resolution training, emotion management, and cognitive restructuring, veterans with PTSD often seemed reluctant to use new skills or give up old ways of coping. Externalization, minimization, and, more importantly, justification of trauma-based coping strategies and beliefs often resulted in patients not feeling the need or responsibility for significantly altering their behavior.

Despite negative consequences, trauma-based perceptions and strategies for coping with safety and interpersonal interactions often feel "right" or appropriate to trauma victims because of their experiences. For example, PTSD patients may view hypervigilance and isolation as effective and justifiable ways of reducing distress and ensuring safety rather than as "symptoms," as labeled by treatment providers. Anger is another example of how patients with PTSD can externalize, minimize, or justify a symptom (Chemtob, Novaco, Hamada, & Gross, 1997; Novaco & Chemtob, 1998). Many treatment-seeking combat veterans are tired of both being angry and the consequences of their anger (e.g., physical damage due to violence, family problems, and legal difficul-

ties). Although such patients come into treatment reporting "anger problems," their view of the problem is often different from that of the therapist. The therapist may assume that patients understand their anger-related behavior as an overreaction to a current situation based on past experiences. In contrast, the patient often firmly sees his anger as a normal response to any interaction with what they view as a hostile, provocative world full of people who are careless, unaware of danger, uncaring, and threatening (DiGiuseppe, 1995; DiGiuseppe, Tafrate, & Eckhardt, 1994). We have frequently heard PTSD-diagnosed veterans say that "the average guy is stupid" with regard to trust or potential harm in the day-to-day world.

Treatment staff and patients are often unaware of how their differing assumptions impact the therapeutic alliance. Treatment providers often label patients' lack of practice or use of coping tools as resistance or symptom chronicity, attributing this to a personality trait of denial or oppositionality, IQ problems, psychodynamic defenses, bad attitude, or a general fear of change. Even if therapists and clients agree on what problems the client is facing, they may have two opposite views as to the cause of the problems and what needs to be changed (Newman, 1994). In our experience in the Veteran's Affairs (VA) PTSD treatment system, treatment providers have often experienced some PTSD patients as resistant, distrustful, and externalizing with regard to their difficulties (McBride & Markos, 1994; Zaslov, 1994). In the past, viewing treatment resistance as a personality or attitude problem inherent among veterans with PTSD led to the implementation of therapeutic community techniques that included confrontation or "attack therapy" as the preferred way of dealing with the perceived resistance. Such confrontational approaches, which have been used with substance abusers, batterers, and other populations, conflict with the need to establish empathy and a climate of safety within which trauma issues can be addressed (Murphy & Baxter, 1997; Nace, 1988; Newman, 1994). In our view, it is critical to avoid blaming trauma survivors for difficulties with distrust and avoidance, both symptoms of PTSD.

A STAGES OF CHANGE APPROACH TO PTSD SYMPTOMS AND RELATED PROBLEMS

We therefore began to consider resistance, ambivalence about change, and symptom chronicity among veterans with PTSD within the Transtheo-

retical Model, particularly the Stages of Change (Prochaska & DiClemente, 1983). The Transtheoretical Model assumes that modifiable beliefs about the need to change, rather than personality traits of denial or negative attitude, underlie the behavioral change process and response to treatment. The Stages of Change conceptualization describes five stages associated with different beliefs about the need to change and actions towards change. These stages include lack of awareness that a problem exists (Precontemplation), ambivalence about the need to change (Contemplation), taking initial steps toward change (Preparation), engagement in efforts to change (Action), and maintaining change (Maintenance). A key assumption in the Transtheoretical Model is that different psychoeducational or therapeutic techniques are needed at each stage to help individuals resolve questions about the need or ability to change that behavior and move to the next stage.

The model has most often been applied to smoking and substance abuse (Prochaska, DiClemente, & Norcross, 1992) but has been extended to a variety of other patient populations (Rosen, 2000), including male batterers (Daniels & Murphy, 1997; Levesque, Gelles, & Velicer, 2000). Readiness-to-change variables have been found to predict psychotherapy dropout (Brogan, Prochaska, & Prochaska, 1999; Smith, Subich, & Kalodner, 1995) and substance use (Belding, Iguchi, & Lamb, 1997; Heather, Rollnick, & Bell, 1993). Motivation enhancement interventions based on the Transtheoretical Model have been effective in reducing HIV risk behaviors (Carey, Maisto, Kalichman, Forsyth, Wright, & Johnson, 1997) and alcohol use by college students (Borsani & Carey, 2000), problem drinkers (Miller, Benefield, & Tonigan, 1993), and alcoholics high in anger (Project Match Research Group, 1998). Studies among trauma survivors have applied the transtheoretical model to readiness for change among adult survivors of child abuse (Koraleski & Larson, 1997) and safety and relationship behaviors of battered women (Feuer, Meade, Milstead, & Resick, 1999; Wells, 1998).

In a study of beliefs about the need to change PTSD-related symptoms and problems among veterans in inpatient PTSD treatment (Murphy et al., 2004), patients were asked to report any problems that they "Might Have," defined as problems that they wondered if they had or that other people told them that they had, but they disagreed. These "Might Haves" were listed separately from any problems that patients were sure that they had ("Definitely Have") or sure that they did not have ("Don't Have"). Results indicated that the patients reported a wide range of categories of PTSD symptoms and related behaviors as "Might

Have" problems, with the highest percentage of patients (48%) classifying anger as a "Might Have." Approximately one-third of the patients labeled isolation, depressive symptoms, trust, and health as a "Might Have," and about one-fourth reported conflict resolution, alcohol, communication, relationship/intimacy, restricted range of affect, and drugs as "Might Haves." Other types of PTSD-related problems (e.g., hypervigilance) were reported as "Might Haves" by 15-21% of the patients. Importantly, preliminary unreported analyses indicated that PTSD symptom severity levels as measured by the intrusions, avoidance, and hyperarousal subscales of the PTSD Checklist (PCL; Blanchard, Jones-Alexander, Buckley, & Forneris, 1996; Weathers, Litz, Herman, Huska, & Keane, 1993) did not differ between groups of patients who acknowledged definitely having a particular PTSD-related problem and those who did not. Another study of combat PTSD patients entering treatment with severe histories of anger and alcohol problems (Rosen et al., 2001) found these patients varied markedly in their awareness of and commitment to changing these problems.

We have adapted the Stages of Change for conceptualizing readiness to change PTSD symptoms, related behaviors and cognitions, and common comorbid conditions (see Table 1). This model includes identification of the specific intervention necessary to move an individual up to the next stage of readiness to change, or belief about the need to change. We have emphasized the conceptualization of the cognitive state of an individual in the form of a question that is unique to each stage, with particular interventions best suited for helping an individual answer that question (Miller, 1985; Miller & Rollnick, 1991; Prochaska & DiClemente, 1983). For any particular problem behavior, individuals in the Precontemplation stage do not believe that they have a problem (i.e., "What problem?"). Here, education about what constitutes a problem (e.g., hypervigilance, substance abuse, or PTSD in general) helps individuals move to the second stage, Contemplation. In this stage, individuals may begin to consider the need for change (i.e., "Do I need to change?"). Decisional balance techniques and comparison of one's behavior to population norms would be applicable for individuals at this stage to help resolve ambivalence about the need to change. Once convinced of the need to change, individuals taking some initial steps toward change may still be doubtful about their ability to complete the change process (i.e., "Can I change?"). Peer modeling and mastery experiences are helpful in the Preparation stage in building self-efficacy and promoting hope for change. The final stages are Action, in which individuals are actively making behavior changes, and Maintenance, in which they are doing what is necessary to

TABLE 1. Stage of Change Model for PTSD (after Prochaska, DiClemente et al., and Miller, Rollnick et al.)

Stage	Description	Question	Intervention
Precontemplation	Person is not considering or does not want to change a particular behavior	"What problem?"	• Education about PTSD *in general*
Contemplation	Person is certainly thinking about changing a behavior	"Do I need to change?"	• Pro's & Con's • Comparison to Norms
Preparation	Person is seriously considering and planning to change a behavior and has taken steps towards change	"Can I change?"	• Education about how therapy works • Expose to successful peers • Mastery experiences
Action	Person actively doing things to change or modify behavior	"How do I change?"	• Skill-building • Homework • Practice, role-play
Maintenance	Person continues to maintain behavioral change until it becomes permanent	"How do I keep change?"	• Lifestyle change • Continue support • Relapse prevention

maintain the behavioral change. Skill-building, practice, reinforcement, and relapse prevention are best implemented in these latter stages.

Within the Motivational Interviewing and Stages of Change frameworks, resistance is due to factors such as a lack of awareness of or sensitivity to negative consequences, the presence of emotional, cognitive, or practical roadblocks to change, and the perception of problem behaviors or consequences as normative. PTSD patients' perceptions about what is normal with regard to problems such as aggressiveness, emotional expression, mistrust, hypervigilance, violence, and substance use may be based on early childhood experiences, military training, warzone experiences, and post-military lifestyle or traumatic incidents. In addition, veterans with PTSD have often chosen partners and friends who reinforce the acceptability of isolation, conflict, emotional masking, and hypervigilance. This conceptualization can help therapists to understand patients' unwillingness to acknowledge a problem and to avoid using labels like "denial" or "not ready to change."

DEVELOPMENT OF THE PTSD MOTIVATION ENHANCEMENT GROUP

As we began to reconceptualize our patients' difficulties in engagement in and utilization of treatment within the readiness-to-change model, we proceeded to develop and implement a brief therapy group, the PTSD Motivation Enhancement (ME) Group (Murphy, Rosen, Cameron, & Thompson, 2002). Our description of this group is followed by preliminary data supporting its potential value in enhancing patients' readiness for change. It is important to emphasize, however, that randomized control studies of the group have not been completed, and so conclusive statements about the group's effectiveness in motivating patients to change PTSD symptoms and related behaviors await further research.

The PTSD ME Group is conceptually based on the Stages of Change and draws on interventions from the literature on Motivational Interviewing techniques (Miller, 1985; Miller & Rollnick, 1991). The group targets any PTSD symptom or related problem behavior (e.g., anger, hypervigilance, owning weapons, depression, substance use, smoking, and other health behaviors) that patients report ambivalence about changing or feel no need to change. The goal of the group is to help patients make decisions about the need to change any behaviors, coping styles, or beliefs not previously recognized as problematic in order to increase patient engagement in treatment and promote adaptive post-treatment coping. In other words, the group is intended to help patients shift from the Precontemplation or Contemplation stages to Preparation or Action with regard to specific problems they previously dismissed or minimized. The seven-session group is designed to meet the needs of managed-care environments that require manualized brief treatments that have measurable outcomes, with built-in program evaluation and assessment of patient satisfaction.

It is important to emphasize that the PTSD ME Group is intended to be a supplement to PTSD treatment programs rather than a "stand alone" treatment. This intervention is intended to enhance clients' active participation in direct PTSD treatment programs, particularly those aiming at symptom amelioration by means of cognitive restructuring, coping skills training, and direct therapeutic exposure. The desired outcome of participation in the PTSD ME Group is increased patient engagement in therapeutic tasks and skills rehearsal, which in turn promote changes in symptoms and adaptive functioning.

Structure and Content of the PTSD ME Group

Rationale

In the first part of every group session, group leaders present the rationale and the purpose of the PTSD ME Group to the participants. The rationale presented is that post-treatment relapse to PTSD symptoms or related difficulties may not be due to inadequate treatment or "unfixable" patients, but rather to unacknowledged problems that lead to gradual or sudden return to old coping styles. For example, social isolation and excessive alcohol use often lead to disconnection from support, poor judgement, and rumination, resulting further in depression, increased hypervigilance, intrusive thoughts, anger, and loss of control. As presented to group participants, the purpose of the group is to help patients make decisions about problems that they *might* have with regard to whether or not behavioral change is needed for a particular behavior or belief. More specifically, the goal is to help patients decide whether these behaviors or problems they "Might Have" are either definitely or definitely not a problem requiring change. A clear distinction is drawn between problems listed as "Might Have" and behaviors and cognitions that they definitely are convinced they need to change. The reasons why it might be useful to make decisions about problems they might or might not have are elicited from the group and expanded upon by the group leaders. Thus, the ultimate goal for patients is to avoid getting blindsided by unacknowledged problems following discharge.

Therapeutic Mindset

The PTSD ME Group is as much a mindset as a set of specific techniques. Our approach is informed by key principles of motivational interviewing (Miller & Rollnick, 1991). These include establishing empathy, highlighting discrepancies between patient's own goals and behavior, avoiding argumentation, rolling with resistance, and supporting self-efficacy. The therapist's role is explicitly as a consultant who provides input to patients' decisions rather than as an expert who bestows his or her own conclusions. This Socratic stance is consistent with the social psychology literature showing that encouraging people to weigh and integrate new information produces more enduring attitude change than encouraging people to simply trust an expert's authority (Petty & Cacioppo, 1984). Although the PTSD ME Group involves highly structured exercises, these exercises are explicitly designed to allow clients autonomy to choose which problems to focus on, grapple with

decisions, and conclude for themselves whether the results of a given session indicate they need to change.

In implementing the group, group leaders should follow the overall approach recommended by Newman (1994) and Miller and colleagues (Miller, 1985; Miller & Rollnick, 1991): being objective and non-confrontational, and always using empathic listening techniques to address patients' responses, no matter how oppositional they might seem. We have found that many clinicians, regardless of experience, have difficulty taking a non-confrontational stance with provocative and externalizing patients. Yet maintaining an objective and supportive stance is especially important when working with angry and provocative patients (DiGiuseppe et al., 1994; Murphy & Baxter, 1997). The importance of maintaining empathy is underscored by the research finding that therapist empathy and client report of the working alliance is the most consistent predictor of psychotherapy outcome (Horvath & Luborsky, 1993; Horvath & Symonds, 1991; Miller et al., 1993).

General Structure

The sequence of groups was designed in a rolling admissions context where participants may enter the group at any module. The group protocol consists of seven group sessions: six sessions with four separate group modules (two modules are repeated) and a seventh session repeating the first group attended (see Table 2). This seventh session was added because some veterans can be disoriented or have some difficulty understanding group content in their first session after entering treatment. To further accommodate the effects of rolling admissions and the extent of memory and attention deficit in aging veteran populations, behavioral learning principles of repetition and rehearsal are used by reviewing the purpose, rationale, and format of the group during the first half of each of the seven group sessions. In this review period, time is given to individualized identification of "Might Have" problems. This review is accomplished by asking questions of the group and allowing more experienced members to answer, thereby educating and acculturating the newcomers. The second half of each session consists of discussion of module-specific tools that will assist patients in deciding whether or not problems that they might have are behaviors they need to change. Group leaders follow a manualized protocol, but the format is interactive and makes extensive use of a whiteboard and patient worksheets.

TABLE 2. PTSD ME Group Session Outline

Session	Group Module	Tasks/Material Covered
Session 1	Group Overview	- Review purpose and potential value of the group - Generate list of problems Definitely Have, Might Have, Don't Have
Sessions 2 & 3	Comparison to the Average Guy	- Review purpose and potential value of the group - Generate list of problems Definitely Have, Might Have, Don't Have - Patients compare their behavior to estimated age-appropriate "norms" in order to help them judge how problematic their behavior might be
Sessions 4 & 5	Pro's & Con's	- Review purpose and potential value of the group - Generate list of problems Definitely Have, Might Have, Don't Have - Decision balance techniques used to help patients decide about the need to change "Might Be A Problem" behaviors which they agree they do, but are not sure are actually problematic
Session 6	Roadblocks	- Review purpose and potential value of the group - Generate list of problems Definitely Have, Might Have, Don't Have - Identify fears, cognitive distortions, and stereotype beliefs that prevent problem identification
Session 7	In rolling admission context, patient repeats first group attended	

Group Content

A key part of the group is having patients generate a list of problem areas that might be a problem for them. This process occurs in the first half of every session, following the general review of rationale and purpose. At that time, patients fill out a worksheet that is divided into three columns: "Definitely Have," "Might Have," or "Definitely Don't Have" (see Figure 1). The "Might Have" column is further divided into two categories: "A Problem You Have Wondered If You Have" and "A Problem Other People Say You Have (But You Disagree)." We have defined "Might Have" problems in these two ways to elicit not only problem areas that they have considered as possibly needing change (i.e., on which they are in Contemplation stage), but also problems that they might be unaware of or unwilling to change (i.e., Precontemplation stage). The goal is for patients to eventually sort items listed under "Might Have" into "Definitely Have" or "Definitely Don't Have."

Group Modules

In the first module (Session 1), "Group Overview," the purpose and potential value of the group is reviewed in detail. Time is also used for reviewing the worksheet on which patients identify problems they "Might Have." The second module, "Comparison to the Average Guy" (Sessions 2 & 3), is aimed at helping patients compare their behavior to estimated age-appropriate but non-PTSD "norms" in order to help them judge how problematic their behavior might be. Behaviors are catego-

FIGURE 1. "Form #1" Worksheet for PTSD ME Group

Problems You DEFINITELY HAVE	MIGHT HAVES: Problems you might have: You have wondered if you have	MIGHT HAVES: Problems you might have: Problems other people say you have but you disagree	Problems You DEFINITELY DON'T HAVE

rized along a range including "Average," "Moderate Problem," and "Extreme Problem." Three dimensions are used to assess behavior at each of these levels: frequency, severity of consequences, and purpose. Group leaders guide members in analyzing what a particular behavior would look like at each of the three levels on each of the three dimensions. For example, if hypervigilance was the behavior selected, group leaders would first elicit a description of normative levels of safety awareness, including checking door locks at night and installing motion-sensitive lights outside. Minor consequences of this normative level would be mild other than the cost of the lights, with the purpose being to feel reasonably safe. Next, there is discussion about what constitutes a moderate level of excessive caution or security-consciousness, such as checking doors twice and getting an attack dog, with consequences including more time and money invested, and intimidating people with the dog. The purpose here begins to take on more of an anxiety-reduction role. Extreme levels of caution, or hypervigilance, may include checking the perimeter of the house throughout the night, keeping a gun under the bed, having multiple weapons, and setting booby traps. At this level, consequences are increased time and energy spent and risk to children, with the purpose of these behaviors involving feelings of survival and a sense of a "life or death" situation.

In the third module, "Pros & Cons" (Sessions 4 & 5), decision balance techniques are reviewed and practiced to help patients decide about the need to change "Might Have" behaviors that they acknowledge doing, but they are not sure are actually problematic. In this simple but effective technique, patients weigh the advantages and disadvantages of various PTSD symptoms and related behaviors, such as gun ownership, hypervigilance (e.g., "setting perimeters"), needing to be in control, a general mistrust of others, social isolation, or continued substance use.

The final module, "Roadblocks" (Session 6), focuses on beliefs or feelings that make it difficult to even consider the need to change. Common roadblocks to considering change include fears, cognitive distortions, and inaccurate stereotypes about what it means to have a problem. Fears of being overwhelmed by problems or being rejected if problems are acknowledged are some of the roadblocks reviewed. Also, there may be cognitive distortions and errors, such as "all or nothing thinking" (e.g., "If I admit to having one more problem, I will have to acknowledge being a complete failure") or blaming of others. Stereotypes of what it means to be an alcoholic (e.g., the town drunk, homeless) or a psychiatric patient ("another crazy Vietnam veteran") can cause reluctance to admit to an alcohol problem or avoidance of psychotherapy.

The group generates a variety of possible roadblocks and participants are instructed to fill out their worksheet to identify and list only those that apply to them. Psychological issues related to shame and guilt frequently arise in the context of this group. The collaborative process provides a supportive context in which veterans can normalize and experience the universality of their feelings, and recognize personal roadblocks to considering the need for change.

Group Process

For successful implementation of the PTSD ME Group, it is important to promote interaction and active participation during the group sessions so that patients gain a sense of ownership of the therapeutic process and their decision-making (Newman, 1994; Rosen & Sharp, 1998). Active engagement in group tasks may also help participants to better comprehend, remember, and apply the concepts and information learned. Although the facilitator provides an overall structure to the discussion, patients are encouraged to verbalize their responses so that more active, insightful, or adept group members can serve as role models and facilitate observational learning with regard to the practical aspects of group participation. This also creates an atmosphere of openness and helps prompt anxious or distrustful members to participate. To enhance this process, we encourage facilitators to ask group members to provide answers to questions from fellow participants. Most importantly, patients are encouraged to use the process to draw their own conclusions about whether they need to change any particular behavior. This helps reduce patient reactance and oppositional responding, which is especially important given that many patients have been in treatment settings where ambivalence or disagreement with therapists has been met with confrontation, being labeled as "not ready for treatment" or "resistant," or threats of discharge.

THE PTSD ME GROUP: CLINICAL CONSIDERATIONS

Selecting Appropriate Patients for the PTSD ME Group

The PTSD ME Group has been implemented most extensively with veterans whose PTSD is long-standing and arose from multiple traumatic experiences, sometimes over their entire lifespan. These patients often have a complicated symptom picture with many varied PTSD symptoms and related problems. The PTSD ME Group, therefore, was

designed to address patients experiencing a variety of problems, with the assumption that there will be variation in readiness to change across different PTSD symptoms and other problems. The PTSD ME Group, then, may not be appropriate for individuals with a recent, single-incident trauma, for example, with a circumscribed set of trauma symptoms and less general life dysfunction. Some of the PTSD ME Group techniques, however, may be helpful for such a patient who seems ambivalent or unaware of the need to change certain coping behaviors or beliefs related to the traumatic event.

As with any group intervention, candidates for participation in the PTSD ME Group should be able to tolerate group process, cooperate with peers, and contribute to an atmosphere of physical and emotional safety in the group. We have found that patients who were unable to form bonds with veteran peers, especially in an inpatient setting, did not find the group useful and could be disruptive despite our best intervention efforts. More specific to the PTSD ME Group, some patients who refuse to consider that they can be unaware of or ambivalent about the need to change any behavior or belief do not get much benefit from the group. This includes patients who have a strong "all or nothing" cognitive style. For some of these patients, review of the PTSD ME Group rationale, taking an empathic approach, and discussion of possible roadblocks to problem acknowledgement helps patients take advantage of the group. In addition, having the patient identify "all or nothing thinking" as a possible problem can be beneficial.

Troubleshooting Difficult Situations

In any group treatment, participants may become oppositional, negative, or disruptive. In the PTSD ME Group in particular, this has taken the form of attacks on the value of thinking about possible unacknowledged problems and anger about the perceived lack of relationship of the group to coping with PTSD. In addition, we have often had veterans strongly express that the PTSD ME Group does not address their betrayal by the government, and they want the therapists to allow discussion of what they see as the critical issue in the treatment of their distress. We have found it helpful, consistent with the mindset discussion above, to avoid labeling a difficult patient as disruptive, and instead conceptualize the situation as arising from the patient not yet understanding the rationale and potential value of the group. Also, patients who have difficulty grasping the content of the group may be expressing their frustration in a more externalizing manner. We have found that

some aspects of the PTSD ME Group can be difficult to comprehend at first, including the "Comparison to the Average Guy" module, the "Might Have" concept, and how this concept relates to the goal of the group. Further, some patients are overwhelmed by the volume of information presented, especially patients with poor cognitive functioning related to substance use.

In general, some potential problems can be averted by making sure that the rationale and goal of the group have been carefully presented at the outset, particularly that symptom exacerbation after treatment may be related to the patient "missing something" in their understanding of their distress. We also will acknowledge that being in therapy can be difficult, and we encourage patients to not let all their hard work go to waste by letting unresolved issues or strong feelings interfere with their engagement in treatment. As always, reflective listening to patient concerns is invaluable in gaining patient trust and cooperation, and actually is most effective when those concerns have been expressed negatively. In addition, questions or expressed frustration about the content of the group can usually be reframed by the therapist as helpful to the group (e.g., acknowledging that the patient's questions or concerns are understandable and give the leaders an opportunity to clarify points that can be hard to understand). This is important because we feel that too many therapists overestimate their ability to use jargon-free language that is consistent with the average person's educational background and level of psychological mindedness. For patients who are becoming excessively hostile, limit-setting is necessary, although best done by calmly but firmly clarifying what behaviors or phrases are unacceptable. Even at this point, patients often respond well to explanations about why the limits exist (e.g., to preserve therapeutic process, assist patient in goals of self-control and communication, etc). Appropriate confrontation in therapy can include discussion with a patient about how their behavior relates to their goals, values, and reasons for coming to treatment.

EVALUATING PATIENT PROGRESS IN THE PTSD ME GROUP

Assessing patient response to the PTSD ME Group can give therapists more specific guidance to patients in utilizing the group effectively, provide some positive feedback to patients about their participation, and prompt therapists to consider modifications in how they are running the

group. We recommend assessing changes in problem awareness and ambivalence, and clinical indicators of patient change.

Tracking Changes in Problem Ambivalence or Awareness

At the end of every group, each participant is asked to list on the Weekly Review Form any problems that they identified as "Might Have" during the course of that particular session. In addition, patients are asked to report if they re-classified any previously identified "Might Haves" as "Definitely A Problem" or "Definitely Not A Problem" at any time during that group session. These data can be kept for each patient to track individual changes in beliefs about the need to change the "Might Haves" over the course of the group.

Clinical Indicators

The PTSD ME group is intended to improve patients' symptoms and functioning by increasing active participation in other components of PTSD treatment. Useful measures of patient progress, then, would be indices of patient's engagement in other PTSD treatment program components. This could include data from other treating clinicians on patient completion of therapy and homework tasks, skills rehearsal, reports of real-world coping skills use, and clinician ratings of therapy engagement.

PTSD ME GROUP: INTEGRATION INTO PROGRAMS

The PTSD ME Group, as a brief therapy intervention, was designed to be used as an adjunctive treatment within a larger treatment program. We discuss below three models for how this group can be integrated into a more comprehensive PTSD treatment plan: as a concurrent adjunct treatment, as a preliminary phase of treatment, and as a module within ongoing semi-structured group therapy. We also discuss relative advantages of open versus closed groups.

Concurrent Adjunct Treatment

In our first major trial at the National Center for PTSD in Menlo Park, the PTSD ME Group was run concurrently with all other treatment components in a 60-day inpatient VA PTSD program. An advan-

tage of this approach is that it provides a forum for continually working through ambivalence issues that may ebb and flow over the course of treatment, and for integrating feedback patients receive from other milieu members. However, an important disadvantage of running the group over the same time period as other groups and activities is that patients may be introduced to various coping skills before they have time to decide which elements they need. For example, given that almost 50% of patients may be ambivalent about anger being a problem for them, a number of participants in anger management groups may be less motivated to learn, practice, or use new ways of dealing with anger.

Preliminary Phase of Treatment

Having the PTSD ME Group near the beginning of treatment may further enhance the therapeutic process, when patients are developing goals and objectives. This is the model used in the PTSD Outpatient Clinic at the New Orleans VA Medical Center, where PTSD ME Group is currently used as part of the second of five phases of treatment. After veterans complete four weekly PTSD Education Group sessions, patients then move to the PTSD ME Group and a case management group where they begin to identify problems, develop treatment plans, and discuss progress. This prepares patients to actively participate in the third, fourth, and fifth phases of treatment, which respectively address coping skills, developmental issues, and relapse prevention. It is hoped that placement of the PTSD ME Group in this sequence affords patients the opportunity to enter the more active phases of treatment with increased awareness of their potential difficulties and greater clarity about their personal treatment goals. An alternative to this phase approach would be to offer a two or three session version of the PTSD ME Group to patients who are considering whether or not to start or continue treatment, in order to help patients make better decisions about the need to begin involvement in therapy or engage in additional treatment components.

Treatment Module Within an Ongoing Process Group

In the VA, many PTSD patients are treated in ongoing process-oriented or supportive therapy groups. The PTSD ME Group could be used as a monthly or occasional module within such ongoing groups to help clients continually clarify their current treatment goals and priorities.

Open vs. Closed Groups

The PTSD ME Group is most simply implemented within a closed group, where all patients are introduced to the same material at the same time. However, this group has also been implemented as an open group within a treatment program with rolling admissions. Although this required more flexibility and repetition to accommodate new members, the open group format had the unexpected advantage of creating a mix of senior and new patients in the PTSD ME Group. This allowed more senior peers to act as advisors and role models for newer members of the group, which enhanced learning for both newer and senior members.

PRELIMINARY FINDINGS ON PTSD ME GROUP EFFECTIVENESS

Findings from our uncontrolled evaluation study of the PTSD ME Group (Murphy et al., 2004) will only be briefly summarized here. Data were collected over an 18-month period from 243 inpatients that attended the PTSD ME Group during their stay in a VA PTSD treatment program. Over the course of the group, veterans on average reclassified approximately 40% of all items they initially listed as "Might Have" to either "Definitely Have" or "Definitely Don't Have." For patients who classified various problems as "Might Have," by the end of their participation in the group significantly more veterans reclassified anger, isolation, anxiety, authority, guilt, emotional masking, relationship/intimacy, smoking, and trust problems as "Definitely Have" than "Definitely Don't Have." Group participants reported high levels of satisfaction with all aspects of group content and process, and gave high ratings on helpfulness (Franklin, Murphy, Cameron, Ramirez, Sharp, & Drescher, 1999). Findings also indicated that compensation status and ethnicity were significantly related to reported frequency of problem awareness or ambivalence or changes in these variables (Murphy et al., 2000). Although definitive statements about the effectiveness of the group await controlled trials, these initial findings indicate that patients are responding to the group as predicted.

READINESS TO CHANGE AND PTSD TREATMENT OUTCOME

The ultimate goal of participation in the PTSD ME Group is improvement of post-treatment functioning. Currently, PTSD treatment

programs usually focus on teaching veterans new coping behaviors and self-talk with the aim of suppressing or replacing maladaptive behavior, cognitions, and emotions. Even many exposure-based treatments, including stress inoculation training, are based on having patients approach feared or unpleasant cues and memories without resorting to avoidance-based coping strategies. These approaches are based on the assumption that this chronic population of VA patients is ready to give up long-held styles of thinking and acting. However, patients are less likely to learn new coping behaviors or ways of thinking if they are unconvinced about the need to change any old ways of acting and thinking. If patients are not convinced that a particular reaction or behavioral response to stress is a PTSD-related problem, they may make less use of new coping tools for those problems or fail to apply newly learned skills outside the immediate treatment setting.

The ultimate goal of our ongoing research efforts is to determine if the addition of a PTSD ME Group to a PTSD treatment program results in better learning, practice, and implementation of coping skills, which in turn should produce better post-treatment functioning. We hope that this motivational enhancement intervention, although still under development, may offer a new approach for increasing the effectiveness of PTSD treatment and prompt reconsideration of current attributions for PTSD treatment failure and the disorder's chronicity among veterans. Further evolution of the PTSD ME Group and judgement of its value, practicality, and long-term impact on patient functioning will be based on the results of research and on feedback from clinicians implementing the group.

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